6.12A

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FROM: Human Resources Department

SUBMITTAL DATE:
October 8, 2009

SUBJECT: 2010 Local Advantage Plus and Local Advantage Blythe Dental Plans - Summary Plan Document and Fee Schedule

RECOMMENDED MOTION: That the Board 1) approve the revised Summary Plan Documents for the Local Advantage Plus and Local Advantage Blythe Dental plans (Attachment "A"); 2) approve the Local Advantage Fee Schedule, for the period of January 1 through December 31, 2010 (Exhibit "1"); 3) authorize the chairperson to sign four (4) copies of the document; and 4) retain one (1) copy of the signed document and return three (3) copies to Human Resources for distribution.

BACKGROUND: The Local Advantage Plus and Local Advantage Blythe Dental plans are County self-insured dental plan options administered by American Dental Professional Services (ADPS). Originally contracted with the County in January 1999, the Local Advantage Plus and Local Advantage Blythe Dental plans are competitive alternatives to the County's other dental plan options.

Ronald W. Komers
Asst. County Executive Officer/Human Resources Dir.

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 0	**In Current Year Budget:**	Yes
	Current F.Y. Net County Cost:	$ 0	**Budget Adjustment:**	No
	Annual Net County Cost:	$ 0	**For Fiscal Year:**	2009/10

SOURCE OF FUNDS: Employee and Retiree Dental Insurance Premiums

Positions To Be Deleted Per A-30 ☐

Requires 4/5 Vote ☐

C.E.O. RECOMMENDATION:

APPROVE

BY: Karen L. Johnson

County Executive Office Signature

FORM APPROVED COUNTY COUNSEL
BY: TAWNY V. LIEU DATE 10/13/09

Departmental Concurrence

☒ Policy ☐ Consent

☒ Policy ☐ Consent

Dep't Recomm.:

Per Exec. Ofc.:

Prev. Agn. Ref.: | **District:** | **Agenda Number:** 3.35

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ATTACHMENTS FILED WITH THE CLERK OF THE BOARD

BACKGROUND (continued):

The 2010-2011 Summary Plan Document, Attachment "A" has been revised to clarify services and provide guidance for employees and their covered dependents regarding plan benefits. Plan limitations and exclusions were clarified to state provisions for:

- Out-of-network Pediatric Dentist, as an excluded benefit;
- Specialty services covered at 50%, the benefit level was not previously stated;
- Surgical Implants as an excluded benefit; and
- General Anesthesia as a covered benefit when used for a covered oral surgery procedure.

The provider reimbursement fee schedule listed as Exhibit "1" has been revised to incorporate American Dental Associations (ADA) procedure code changes and ensure ADPS administers the County's dental plans in compliance with ADA guidelines.

There is no direct cost to the County associated with the recommended action, employees and retirees pay premiums for the services.

ATTACHMENT "A"

LOCAL ADVANTAGE PLUS
LOCAL ADVANTAGE BLYTHE
DENTAL PLANS

SUMMARY PLAN DOCUMENT

APPROVED FOR PLAN YEARS 2010 - 2011

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INTRODUCTION

The plan is specifically designed by the County of Riverside for County of Riverside employees and their eligible dependents. This Dental Plan provides dental care services through a network of participating dentists and dental groups throughout the County of Riverside. The plan benefits include extensive coverage to meet your dental care needs such as preventative care, restorative services, specialty services, and orthodontia. This Summary Plan Document provides a detailed description of how this plan works and the coverage provided to you. Detailed benefit explanations are included along with an explanation of your responsibilities as a member of this plan.

The plan provides certain services at no charge to you. For other procedures, you pay a co-payment at the time the services are received.

Benefits/Coverage/Claims Questions

If you have any questions about your benefits under this plan, or how the plan works, a representative is available to answer your questions at the office of the plan's Claims Administrator. This office can be reached at: **888-540-9488**

Dental Provider/Network Questions

If you require information about a specific network dentist, or you wish to speak to someone about your network dentist, or you have questions about the network in general, a representative is available to answer your questions at the office of the plan's Claims Administrator. This office can be reached at: **1-888-540-9488.**

This Summary Plan Document will be the primary governing document for all plan coverage decisions and will be the basis for final determination for the provision of benefits. This plan is intended to comply with all laws and regulations that are applicable whether or not specifically described in this Summary Plan Document.

DENTAL PLAN ADDRESSES AND TELEPHONE NUMBERS

Dental Plan Claims Administrator/Member Services:
American Dental Professional Services
9054 N. Deerbrook Trail
Milwaukee, WI 53223
888-540-9488

DEFINITIONS

Annual Enrollment - a period of time established by County of Riverside during which eligible employees and retirees may enroll in a dental plan.

Benefits (Covered Services) - those services which a member is entitled to receive pursuant to the terms of the Dental Plan.

Calendar Year - a period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. January 1 of the following year.

Categories of Benefits:

- Diagnostic - procedures to help the dentist evaluate your dental health to determine necessary treatment.
- Preventative - procedures to prevent dental disease (cleanings, for example).
- Restorative - procedures necessary to restore the teeth (other than crowns or cast restorations)
- Minor Restorative - oral surgery, endodontic (root canals), and periodontic (gum) procedures.
- Major Restorative - crowns and cast restorations (caps, veneers, inlays and onlays).
- Prosthodontic - procedures involving bridges and dentures to replace missing teeth.
- Orthodontic - procedures involving appliances (such as braces) or surgery to realign teeth and/or jaws which otherwise do not function properly.

Co-payment - the member's share of the costs to be paid at the time services are received.

Covered Services - those dental services to which the Plan will apply benefit payments, according to the Summary Plan Document.

Dental Plan - Local Advantage Dental Plan.

Eligible Dependent - any of the dependents of an eligible employee who are eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Eligible Employee - any group member or employee who is eligible to enroll for benefits in accordance with the conditions of eligibility outlined in this booklet.

Employer - County of Riverside.

Exclusion - any dental or other treatment for a condition for which the Plan provides no coverage.

Experimental or Investigational - any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or if safety and efficacy have not been determined for use in the treatment of a particular illness, injury or dental condition for which it is recommended or prescribed.

Maximum - the greatest dollar amount the Plan will pay for covered procedures in any calendar year, or lifetime orthodontic benefits.

Medicare - the programs of medical care coverage set forth in Title XVIII of the Social Security Act, as amended by Public Law 89-97, or as thereafter amended.

Member - an employee, retiree or family member enrolled under this Dental Plan.

Network - the dentists and dental groups which are contracting with the Plan to provide its members with treatment and services.

Participating Dentist/Dental Group - an independent provider who has an agreement to provide Plan benefits to Members.

Specialist - a dentist other than a network general dentist who has an agreement with the Plan to provide specialty services to members according to an authorized referral by a network general dentist.

Summary Plan Document - the approved summary description of entire benefits available, including Exclusions and Limitations, under this benefit program.

Services - dental care services and supplies.

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the benefits program if you are a regular County employee scheduled to work at least 20 hours per week. Your bargaining unit determines which plan options are available to you. For more information about your benefit options, please review the information provided in the County of Riverside annual enrollment guide.

Dependent Eligibility
You may enroll your eligible dependents in your dental coverage. Your eligible dependents* include:

- Your legal spouse/registered domestic partner
- Your and/or your spouse/domestic partner's dependent natural children, adopted children, foster children, and stepchildren under age 23 and who has never been married
  - ➢ Any child, who is under age 23 and has never been married, for whom you have legal custody and have been required to cover under your dental plan as part of a qualified child support order, or who resides with you (generally in the absence of the natural or adoptive parent) and who is economically dependent upon you.
  - ➢ An otherwise eligible child past age 23 if the child is incapable of self support because of a mental or physical handicap and you continue to claim the child as a dependent on your federal income tax return.

** Important notes about dependent eligibility:*
1. It is against the law to enroll ineligible family members. If you do, you may have to pay for all costs incurred by the ineligible dependent from the date the coverage began.
2. If you do not add newly eligible family members to your plan within the 60-day period of eligibility, you may enroll them during any future annual enrollment period.
3. Your former spouse, parents, parents-in-law, other relatives, and non-disabled children age 23 and over, are not eligible for coverage under this plan.
4. You must drop coverage for your enrolled spouse/domestic partner or dependent child when he/she loses eligibility (e.g., divorce, your child attains age 23, or marries).

ENROLLMENT
If you are a newly hired or newly eligible employee, you may elect to enroll within 60-days of your hire date or eligibility. All coverage will be effective the first day of the following month after County of Riverside receives and processes your election.

Making Mid-Year Changes
Each year your elections stay in effect from January 1 through December 31, as long as you remain eligible for benefits. During annual enrollment, you have the opportunity to change your coverage elections for the following plan year. However, after the close of annual enrollment you can make benefit changes ONLY if you have a qualified status change. Qualified status changes include:

- Marriage, or gaining a domestic partner
- Divorce, or separation from domestic partner
- Birth or adoption of a child
- Death of a spouse or a child
- Change in spouse's employment

- Significant changes in your spouse's employer's medical coverage
- Child's loss of eligibility due to age, student status, or marital status
- Full-time/part-time employment status change that results in an insurance eligibility change
- Commencement of or return from an unpaid leave of absence

If one of the above events occurs, and you want to make a benefit change consistent with the specific event, you must submit a new Election Form indicating your new coverage elections within 60-days of the event to the County of Riverside.

Remember, it is your responsibility to stay informed about your coverage. If you have any questions, or need additional information, please contact the County of Riverside Benefits Division.

Benefits Information Line (951) 955-4981
Website: http://benefits.rc-hr.com
Email: Benefits@rc-hr.com

CHOOSING YOUR DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

The plan provides easy access to dental care services and there is virtually no paperwork. Members have access to a network of licensed dentists in your local community. The network dental provider listing is available by contacting County of Riverside Benefits Information Line or via the County's website. As a Member of this plan, you are entitled to visit any of these dental providers in the plan network when you need dental care services. You may switch to another network provider without pre-approval at any time.

YOU ARE NOT REQUIRED TO PRE-SELECT A DENTIST AT ENROLLMENT

ALWAYS CALL THE PROVIDER YOU CHOOSE TO VERIFY THE PROVIDER'S PARTICIPATION STATUS

SERVICES PROVIDED BY DENTISTS NOT AUTHORIZED BY LOCAL ADVANTAGE DENTAL PLAN ARE NOT COVERED BY THIS DENTAL PLAN.

Selection of Different Dentists by Enrolled Dependents

As a Member of the plan, you and each enrolled family member may choose to use different dentists within the plan's dental provider network.

Scheduling Appointments

Once you have selected your dentist from the list of participating dentists, simply call the dental office and make an appointment.

Broken Appointment Fees
Broken appointment fees may apply for short cancellation notice.

Referrals To Specialists
The dentist that you select to provide your dental care will refer you to a specialist when treatment by a specialist is appropriate. If the plan dentist refers you to a network specialist (e.g. Periodontist), the plan will pay benefits according to a separate specialist network fee schedule. Please call the plan administrator at **1-888-540-9488** for more information. In the event a referral to a specialist outside the network is necessary, a pre-authorization is required before the plan will coordinate the referral.

NOTE: Reimbursement to a non-network Specialist is limited to the amount the plan would have paid to a network Specialist. Any amount billed over this amount will be your financial responsibility, including any applicable co-payment.

Payment For Dental Services
The plan contracts with individual dentists and dental groups to provide dental services to Plan members. Participating dentists are paid on a discounted fee-for-service basis for each procedure. You are responsible for co-payments. For any services that are not covered under this Dental Plan, payment to the dentist for these services will be your financial responsibility.

For questions regarding covered procedures, please call:
American Dental Professional Services
9054 N. Deerbrook Trail
Milwaukee, WI 53223
1-888-540-9488

NOTE: *Be sure to ask your dentist for a Pre-Treatment Estimate and/or a copy of the proposed treatment plan if extensive dental work is going to be undertaken. This will assist you in making your treatment decisions, and understanding what is covered and not covered under the plan.*

LOCAL ADVANTAGE PLUS
LOCAL ADVANTAGE BLYTHE

SUMMARY OF COVERED SERVICES

THE FOLLOWING SUMMARY IS ONLY A BRIEF DESCRIPTION. PLEASE REFER TO THE BENEFIT LIMITATIONS AND EXCLUSIONS SECTION OF THIS SUMMARY PLAN DOCUMENT FOR FURTHER INFORMATION.

Benefit Maximum: **$1,500 each Member per Calendar Year**

Preventative **100%**

Initial exam - twice per 12 months
Full mouth x-ray - once every 3 years
Bitewing x-ray - twice per calendar year
Cleanings - twice per calendar year

Sealants – Under age 14 to permanent posterior molars with no decay, restorations, and with occlusal surface intact. Does not include replacement or repair of any sealant on any tooth within 3 years of application.

Restorative **90% (1)**

Restorative - Amalgam, synthetic, plastic, resin restorations for treatment of cavities. Posterior composite treatments.

Minor Restorative

Periodontics (2) - Treatment of gums and bones that support the teeth – periodontal cleanings are covered at twice per calendar year.
Extractions (2) - Pre and post operative care
Endodontics (2)- Treatment of tooth pulp

Major Restorative **65% (3) (*)**

Crowns, jackets, inlays, onlays, cast restorations - Are benefits on the same tooth only once every 5 years.
Prosthodontics – Once every 5 years unless there is such extensive loss of remaining teeth that the existing appliance cannot be made satisfactory.

Orthodontic Treatment **Standard Case (4)**

$120.00 Down payment, $120.00 per month for 24 months
Lab fees are not included

Cosmetic Dentistry **50%**

Whitening, bonding, bleaching, veneers

1. Upgrade fee formula for posterior composite fillings are addressed elsewhere in the SPD.
2. These benefits apply for procedures provided by a General Dentist. Specialist referrals are addressed elsewhere in the SPD.
3. Precious metal costs are not included.
4. This discount applies for Orthodontic Services provided by a Network Specialist.

(*) Additional fee charges for porcelain on molar teeth.

DENTAL LIMITATIONS AND EXCLUSIONS

Limitations
The following limitations apply to certain procedures (identified below) under this Dental Plan:

1. You are responsible for any charges made by a non-network provider, including specialists, unless preauthorization is obtained and approved by the plan network service department or plan administrator (ADPS).

2. Cleanings of any kind are benefits no more than twice in any calendar year.

3. Periodontal scaling and root planning is limited to four (4) separate quadrants every 2 years.

4. Sealant benefits are limited to eligible dependent children up to age fourteen (14). Sealant benefits include the application of sealants only to permanent posterior molars without caries (decay), without restorations, and with the occlusal surface intact. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application. Sealants are limited to one (1) each tooth every three (3) years through age ten (10) on permanent first molars and up to age fourteen (14) on permanent molars.

5. Crowns, jackets, inlays, onlays and cast restorations are benefits on the same tooth only once every five (5) years while you are a patient under the plan unless the plan determines that replacement is required because restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissue since the replacement of the restoration.

6. Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The plan covers an acrylic or stainless steel crown.

7. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, and endodontics. Referral to an out-of-network pediatric dentist is specfically excluded. Oral surgery, periodontic and endodontic procedures performed by a specialist are covered at 50%.

8. Full mouth x-rays – one (1) set every three (3) years.

9. Two (2) sets of bitewing x-rays twice per calendar year.

10. Prosthodontic appliances are benefits only once every five (5) years, while you are eligible under this plan, unless the plan determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under the plan will be made if it is unsatisfactory and cannot be made satisfactory. Full or partial denture relines or rebasing are limited to one per arch per 12 consecutive months.

11. Optional treatment provisions: If you select a more expensive plan of treatment than is customarily provided, or speciailzed techniques, an allowance will be made for the least

expensive, professionally acceptable, alternative treatment plan. The plan will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee. *An example would be: When an enrollee receives a composite (white) filling in place of an alloy/amalgam filling when decay is present on a back tooth, the plan makes an allowance toward its cost. The allowance is based on the plan's fee for the equivalent alloy/amalgam filling and the enrollee pays the difference to the posterior composite fee. For cosmetic purposes to replace an alloy/amalgam filling, the plan coverage is 50%.*

12. You must remain on the plan during the period of time you or your eligible dependent(s) is/are undergoing orthodontic treatment. Any early termination will result in pro-rated charges for all unfinished work according to the Orthodontic contract signed at the start of treatment.

13. Implants and any associated abutments (appliances inserted into bone or soft tissue in the jaw, usually to anchor a crown, fixed bridge, partial or denture) are not covered by the plan. However, if implants are provided along with a covered prosthodontic appliance (examples noted above), the plan will allow the benefit for the covered standard prosthodontic appliance supported by the implant in conjunction with all other provisions, exclusions and limitations of the plan. You are responsible for the remainder of the dentist's fees less the plan's benefits

Exclusions – Services The Plan Does Not Cover
No benefits will be covered for expenses incurred:

1. For any procedure not specifically listed as a covered benefit.

2. For procedures that are (a) in the opinion of the dentist are not clinically necessary for your health; (b) services or charges which are necessitated as a result of you failing to follow a documented prescribed course of treatment; (c) services which are obtained outside the Plan network and services which are not pre-authorized by the plan (including specialty services); (d) services or supplies that do not meet accepted standards of dental practice, and/or which are experimental in nature.

3. Grafting tissue - from outside the mouth to tissue inside the mouth ("extraoral grafts"), implants (materials implanted into bone or soft tissue) or the removal of implants.

4. Services for any disturbances of the jaw joints (temporomandibular joints or 'TMJ") or associated muscles, nerves or tissues.

5. For treatment that was started by any dentist prior to your eligibility under the plan, including, but not limited to, orthodontics, endodontics, crowns, bridges, inlays, onlays, dentures, and prior extractions.

6. Charges for replacement or repair of an orthodontic appliance paid in part or in full by the plan. See the Orthodontic contract for specific information on repairs and broken appliances.

7. Extractions of over-retained teeth are not covered.

8. Surgery necessary to correct skeletal imbalances and/or malformations (e.g., orthognathic surgery).

9. Procedures requiring appliances or restorations (except dentures) that are necessary for adult or pediatric full mouth rehabilitation or to alter, restore or maintain occlusion, a change of vertical dimension, restorative equilibration, kinesiology, or consultation for and/or treatment of disturbances of the temporomandibular joint (TMJ).

10. The following are not included as orthodontic benefits: replacement or repair of appliances, orthodontic extractions, special appliances (e.g., Herbst appliances, rapid palatal expanders), retreatment of orthodontic cases, changes in treatment necessitated by patient neglect, and treatment in excess of twenty-four (24) months. See the Orthodontic contract for specific information.

11. For consultation by a specialist for non-covered benefits.

12. Hospitalization costs (and associated fees) for any dental procedures.

13. The plan will not be financially responsible for services determined to be the responsibility of Workers' Compensation or Employees Liability, services for which benefits are payable under any Federal Government or any state program, or for services for treatment of any automobile related injury in which you are entitled to payment under an automobile insurance policy.

14. Prescriptions and medications not normally supplied or dispensed by a dental office (this includes home care items such as rotodents, peridex, tetracycline rinses, etc.).

15. Administration of general anesthesia (other than when administered for a covered oral surgery procedure), intravenous sedation, oral sedation, or the services of an Anesthesiologist.

16. Treatment of bone fractures or dislocations.

17. Treatment of cysts, malignancies, or neoplasms.

18. Treatment of congenital or developmental malformations NOT including deciduous teeth and supernumerary teeth.

19. Implants and associated services (e.g. abutments).

20. Replacement of dentures, appliances, crowns, or bridgework, due to loss or theft or any duplicate prosthetic device or appliance.

21. Precision attachments or stress breakers.

GENERAL PROVISIONS

Reimbursement Provisions
The plan is designed to eliminate claim forms and expenses other than required co-payments. In some circumstances, you may incur expenses for covered services (such as out-of-area emergency care). If this happens, any amount billed over this amount will be your financial responsibility, including any applicable co-payment.

If you receive a bill for covered services, please provide the plan with a copy of the bill within 90 days of the date the service was rendered. Please submit the bill to:

American Dental Professional Services
9054 North Deerbrook Trail
Milwaukee, WI 53223

In the event such a claim is denied, you may resubmit within 90 days of the initial denial, explaining in writing why you believe your claim should be approved.

Complaint And Claims Appeal Procedures
If you have a question or concerns regarding eligibility, you may call the County of Riverside Benefits Information Line: **1-951-955-4981.**

If you have any questions about the services you receive from a plan dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call the plan's claims administrator: **1-888-540-9488.**

If you have a question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of the quality of dental services performed by a plan dentist, you may call: **1-888-540-9488.**

You have 60 days after you receive notice of denial to appeal. If you write, you must include the name of the patient, the group name and social security number or identification number, and your telephone number on all correspondence. You should also include a copy of the treatment form, notice of payment and any other relevant information. Clearly explain your complaint and send it to the plan's claim administrator:

American Dental Professional Services
9054 North Deerbrook Trail
Milwaukee, WI 53223

Arbitration
Arbitration is a vehicle for the resolution of any disputes concerning dental care services or benefits, or contract interpretation (except disputes concerning eligibility for enrollment, effective date of coverage, and malpractice or bad faith).

Arbitration resolves differences pertaining to any personal liability, tort claims, or contract disputes (excluding claims for professional malpractice or bad faith) originating from this agreement.

Pursuant to California law, any claim of up to $200,000 must be decided by a single neutral arbitrator who shall be chosen by the parties and who shall have no jurisdiction to award more than $200,000. However, the plan and the member may agree in writing to waive the

requirement to use a single arbitrator and instead use a tripartite arbitration panel that includes the two-party appointed arbitrators or a panel of three neutral arbitrators, or another multiple arbitrator system mutually agreeable to the parties. The member shall have three business days to rescind the waiver agreement unless the agreement has also been signed by the member's attorney, in which case the waiver cannot be rescinded. In cases of extreme hardship, the *Local Advantage Dental* plan may assume all or part of your share of the fees and expenses of the neutral arbitrator, provided you have submitted a hardship application to the American Arbitration Association. The approval or denial of a hardship application shall be determined by the American Arbitration Association. You may obtain a hardship application by contacting the American Arbitration Association in Los Angeles, or Orange County.

BY ENROLLING IN THIS PLAN YOU ARE AGREEING TO HAVE CERTAIN DISPUTES (MENTIONED ABOVE) DECIDED BY NEUTRAL BINDING ARBITRATION. THE LOCAL ADVANTAGE DENTAL PLAN AND MEMBERS WAIVE THEIR RIGHT TO A JURY OR COURT TRIAL FOR THESE DISPUTES.

The California Department of Insurance is responsible for regulating public agency self-funded health care service plans. The Department has a toll-free telephone number (1-800-927-4357) to receive complaints regarding dental plans. If you have a grievance against the plan, you should contact the plan and use the plan's grievance process. If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by the plan, you may call the Department's toll-free telephone number.

Eligibility Issues

These issues must be referred directly to the County of Riverside Human Resources Department, Benefits Division.

TERMINATION OF GROUP MEMBERSHIP - CONTINUATION OF COVERAGE

Termination of Benefits and Re-Enrollment

Coverage may be terminated for individual members if any of the following events occur:

- An employee, retiree or dependent ceases to be eligible for coverage.
- Voluntary cancellation of coverage by an employee, retiree or dependent.

All rights to coverage and care stop on the date you are no longer eligible. If for any reason the County of Riverside terminates the plan, your coverage will end on the day the plan terminates.

The plan will not terminate or refuse to renew the enrollment of any person because of his or her dental health status or need for dental care services.

Continuation of Coverage (COBRA)

The Federal Consolidated Omibus Budget Reconciliation Act (COBRA) requires that continued health care coverage be made available to "Qualified Beneficiaries" who lose health care coverage under the group plan as a result of a "Qualifying Event." You or your dependents may be entitled to continue coverage under this program, at the "Qualified Beneficiary's" expense, if certain conditions are met. The period of continued coverage depends on the "Qualifying Event." Coverage will be extended 18 months for the Subscriber and eligible family members. A dependent can be eligble for up-to 36 months depending on the qualified event.

The benefits of the continuation of coverage are identical to those provided by the plan and the cost of coverage may not exceed 102% of the applicable current group premium. This coverage may be extended for up to an additional eleven (11) months if you are recognized as disabled by Social Security. This extension of coverage is available at a cost not to exceed 150% of the applicable current group premium. An eligible employee or family member is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the premium is paid. No employer contribution is available to cover the premium required.

PAYMENT BY THIRD PARTIES

Third Party Recovery Process and Your Responsibilities

If you are ever injured through the actions of another (a third party) and receive compensation for your dental care, you will be required to reimburse the plan, or its nominee, for the reasonable value of dental services and benefits provided. The amount of reimbursement shall not exceed the amount of compensation you receive from the third party.

- You must obtain the plan's written consent prior to settling any claim or releasing any third party from liability, if such a release would limit the plan's right to reimbursement.

- Should you settle your claim against a third party and compromise the plan's **reimbursement** rights, the plan reserves the right to initiate legal action. Attorney fees will be awarded to the prevailing party.

- You are required to cooperate in protecting the interest of the plan by providing the *plan* with all liens, assignments or other documents. Failure to cooperate with the plan in this regard could result in membership termination.

Coordination of Benefits

If you or an eligible dependent are covered by the plan and another group dental plan, the plan will coordinate its benefits with those of the other plan only when the patient is seen by a provider within the Plan's provider network. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and to prevent any payment duplication.

- In order to ensure proper coordination, you must inform the plan of any other dental coverage for which you or your dependent (s) may be eligible.

- If the plan pays more benefits than appropriate, the plan may recover excess benefit payments from you, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

Workers' Compensation

If you are receiving benefits because of Workers' Compensation, the plan will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under Workers' Compensation laws, when such payments can reasonably be expected.

If the plan happens, for whatever reason, to duplicate benefits to which you are entitled under Workers' Compensation law, you are required to reimburse the plan, at prevailing rates, immediately after receiving monetary award, whether by settlement or judgment.

In the event of a dispute arising between you and your Workers' Compensation filing, the plan will provide the benefits described in this agreement until the dispute is resolved.

If you receive a settlement of Worker's Compensation that includes payment of future medical costs, you may be liable to reimburse the plan for those costs.

PRIVACY PRACTICES

County of Riverside and American Dental Professional Services, LLC (ADPS) is committed to respecting the privacy of our employees, retirees and customers. We are required by applicable federal and state law to maintain the privacy of your health information.

The Type of Information We May Collect

We collect nonpublic personal information about you from the following sources:

- Eligibility from your Employer
- Transactions with us or our affiliated companies
- Claims submission from dental providers

Information We May Disclose

We do not disclose any nonpublic personal information about our members or former members to anyone, except as permitted by law, unless you specifically request that we do so. We only make those disclosures needed to administer your dental program and as necessary to effect transactions in the ordinary course of business. Any disclosures are only made to our affiliates, agents, or third parties that perform services on our behalf such as account administration or marketing our services or products.

Confidentiality and Security of Your Nonpublic Personal Information

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Any questions or concerns regarding this privacy notice should be directed to our Customer Services Department at 1-888-540-9488.

This document has been reviewed and approved by the County of Riverside's Board of Supervisors, and is the official plan document.

COUNTY OF RIVERSIDE:

By:_____
Chairman, Board of Supervisors

Date:_____

LOCAL ADVANTAGE REIMBURSEMENT SCHEDULE FOR 2010

EXHIBIT "1"

ADA		DESCRIPTION	Fee Schedule	Insur - 100%	Pt Copay - 0%
DIAGNOSTIC & PREVENTIVE					
150		INITIAL EXAMINATION	37.47	37.47	0.00
9310		PERIO INITIAL EXAM	93.68	93.68	0.00
120		PERIODIC/RECALL EXAM	32.79	32.79	0.00
9430		OFFICE VISIT	60.89	60.89	0.00
140		LIMITED EVAL - Problem	40.93	40.93	0.00
9440		PROFESSIONAL VISITS	121.78	121.78	0.00
4110		PERIO EVAL/TX PLAN	51.52	51.52	0.00
1120		PROPHYLAXIS-CHILD	53.56	53.56	0.00
1110		CLEANING-ADULT	63.86	63.86	0.00
1203		Fluoride Child	7.33	7.33	0.00
1204		Fluoride Adult	18.54	18.54	0.00
1351		SEALANT PER TOOTH	35.60	35.60	0.00
9110		EMERGENCY TREATMENT	79.63	79.63	0.00
2970		TEMP/TREATMENT CROWN	0.00	**N/C**	180.00
220		DIGITAL X-RAY-SINGLE	20.61	20.61	0.00
230		DIGITAL X-RAY ADDTL	16.86	16.86	0.00
210		DIGITAL FMX	103.00	103.00	0.00
272		DIGITAL XRY-2 BWX	37.08	37.08	0.00
274		DIGITAL XRAYS-4 BWX	51.50	51.50	0.00
240		INTRAORAL OCCLUSAL	28.10	28.10	0.00
330		PANOREX X-RAY	70.26	70.26	0.00
ORAL SURGERY			**Fee Schedule**	**Insur - 90%**	**Pt Copay - 10%**
7111		EXT DICIDUOUS	96.31	86.68	9.63
7140		EXT,SINGLE,ADD,ROOTTIP	96.31	86.68	9.63
7120		EXTRACTION ADDITIONAL	96.31	86.68	9.63
7210		SUR. EXT. ERPT.TOOTH	196.99	177.29	19.70
7250		REMOVAL OF RES. ROOT	210.78	189.70	21.08
7130		ROOT REMOV-EXPOSED	210.78	189.70	21.08
7220		EXTRACTION, SURGICAL	196.99	177.29	19.70
7230		EXTRACT,PARTIAL BONY	262.65	236.39	26.27
7240		EXTRACT,FULL BONY"	306.43	275.79	30.64
7970		EXCIS. HYPER PLASTIC	402.82	362.54	40.28
7270		REIMPLANATION	355.98	320.38	35.60
7540		REMOVAL FOREIGN BODY	313.82	282.44	31.38
7530		FOREIGN BODY REMOVAL	313.82	282.44	31.38
7960		FRENECTOMY	398.13	358.32	39.81
7910		SUTURE,TISSUE INJURY	281.04	252.94	28.10
7280		CROWN EXPOSURE	398.13	358.32	39.81
7281		CROWN EXPOSURE	327.87	295.08	32.79
9230		ANESTHESIA: NIT OXI	70.26	63.23	7.03
PERIODONTICS - BY A GENERAL DENTIST			**Fee Schedule**	**Insur - 90%**	**Pt Copay - 10%**
4355		FULL MOUTH DEBRIDEMT	126.47	113.82	12.65
4910		RECALL EXTENSIVE TRT	88.99	80.09	8.90
4930		EMG TRT PERIODONTAL	46.84	42.16	4.68
4341		PERIO ROOT PLANING	150.38	135.34	15.04
4342		PERIO RP 1-3 TEETH	115.36	103.82	11.54
4249		CRWN LNGTHN/HRD-SOFT	662.31	596.08	66.23
3450		ROOT AMPUTAT/ROOT	309.14	278.23	30.91
4211		GINGIVECTOMY/TOOTH.	177.99	160.19	17.80
4263		OSSEOUS GRAFT	241.69	217.52	24.17
9940		NIGHT GUARD	374.71	337.24	37.47
4320		PERIODONTAL SPLINT	37.47	33.72	3.75
9952		OCCLUSAL ADJ-COMPLT	421.55	379.40	42.16
486		MOUTHGUARD-LIGHT	91.80	82.62	9.18
4360		SPEC PERIO APPLIANCE	84.31	75.88	8.43

EXHIBIT "1"

487	MOUTHGUARD-MEDIUM	129.28	116.35	12.93
488	MOUTHGUARD-HEAVY	148.01	133.21	14.80
ENDODONTICS - BY A GENERAL DENTIST		**Fee Schedule**	**Insur - 90%**	**Pt Copay - 10%**
3110	PULP CAP	51.52	46.37	5.15
3210	HISTOPATHOLOGIC	112.41	101.17	11.24
3220	PULPOTOMY	140.52	126.47	14.05
3120	INDIRECT PULP CAP	46.84	42.16	4.68
3310	ROOT CANAL - ANTERIOR	515.23	463.71	51.52
3320	ROOT CANAL - BICUSPID	608.91	548.02	60.89
3330	ROOT CANAL - MOLAR	702.59	632.33	70.26
3346	RETREAT RC-ANTERIOR	562.07	505.86	56.21
3347	RETREAT RC-BICUSPID	655.75	590.18	65.58
3348	RETREAT RC-MOLAR	749.43	674.49	74.94
3420	APICO+RC/RETROGRADE	525.30	472.77	52.53
3410	APIC/PERIRA SURG ANT	569.08	512.17	56.91
3920	HEMISECTION,ROOT AMP	281.04	252.94	28.10
3430	RETRO FILLING/ROOT	149.89	134.90	14.99
RESTORATIVE (FILLINGS)		**Fee Schedule**	**Insur - 90%**	**Pt Copay - 10%**
2140	1 SURF AMALGAM	94.69	85.22	9.47
2150	2 SURF AMALGAM	112.72	101.45	11.27
2160	3 SURF AMALGAM	139.77	125.79	13.98
2161	4 SURF AMALGAM	161.97	145.77	16.20
2940	SEDATIVE TEMP FILL	56.21	50.59	5.62
2330	ANTER RESIN-1SURF	121.78	109.60	12.18
2331	2 SURF ANTER COMP	154.57	139.11	15.46
2332	3 SURF ANTER COMP	187.36	168.62	18.74
2335	ANT RESIN:PROX/INCIS	210.78	189.70	21.08
COSMETIC		**Fee Schedule**	**Insur - 50%**	**Pt Copay - 50%**
0	AESTHWHIT REPLACTRAY	23.42	11.71	11.71
0	AESTH WHITN-REFILL	70.27	35.14	35.14
0	AESTH WHITN-2ND ARCH	163.94	81.97	81.97
0	AESTH WHITN-1ST ARCH	163.94	81.97	81.97
3960	BLEACHING PER TOOTH	234.20	117.10	117.10
3962	BLEACHING PER VISIT	131.16	65.58	65.58
2740	CROWN, PORCELAIN	772.50	386.25	386.25
2962	LAMIN PORC VENEER	702.58	351.29	351.29
2961	LAMIN RESIN VENEER	655.76	327.88	327.88
0	ZOOM WHITING	669.50	334.75	334.75
0	ZOOM WHITING REFILL	51.50	25.75	25.75
2391	1 SURF POSTERIOR COMP	144.46	72.23	72.23
2392	2 SURF POSTERIOR COMP	202.24	101.12	101.12
2393	3 SURF POSTERIOR COMP	240.76	120.38	120.38
2394	4 SURF POSTERIOR COMP	264.84	132.42	132.42
CROWN & BRIDGE		**Fee Schedule**	**Insur - 65%**	**Pt Copay - 35%**
2930	CR.,ST.STL/PREF.PRIM	229.95	149.47	80.48
2931	CR.,ST.STL/PREF.PERM	229.95	149.47	80.48
2710	CROWN, ACRYLIC	542.81	352.83	189.98
2720	ACRYLC CRN/HGH NOBLE	702.58	456.68	245.90
2750	CROWN, PORC.W/GOLD	746.75	485.39	261.36
2751	PORC CROWN NONPREC.	612.85	398.35	214.50
2752	PORC CROWN SEMIPREC.	669.80	435.37	234.43
2790	CROWN, FULL GOLD	746.75	485.39	261.36
2791	CAST NON PRECIOUS	569.09	369.91	199.18
2792	CROWN SEMI/PRECIOUS	669.80	435.37	234.43
2810	3/4 GOLD CROWN	590.96	384.12	206.84
6545	MARYLAND RETAINER	280.16	182.10	98.06
2950	CROWN BUILD UP/PINS	196.72	127.87	68.85
2951	PIN RETENTION/TOOTH	42.15	27.40	14.75

EXHIBIT "1"

2954	PREF DOWEL POST&CORE	224.83	146.14	78.69
2952	CAST POST W/CORE	262.29	170.49	91.80
2892	POST FOR CROWN	163.95	106.57	57.38
2933	CR.,ST STL/WINDW-PRE	281.04	182.68	98.36
6520	INLAY-2SURF ABUTMENT	612.85	398.35	214.50
6530	INLAY-3+SURF ABUTMNT	612.85	398.35	214.50
6750	ABUTMENT-PORC/GOLD	746.75	485.39	261.36
6752	ABUTMENT-PORC SEMIPR	669.80	435.37	234.43
6790	ABUTMENT-GOLD	746.75	485.39	261.36
6792	ABUTMENT-SEMIPRECIOU	669.80	435.37	234.43
6780	3/4 GOLD ABUTMENT	656.63	426.81	229.82
6212	CAST SEMI/PREC PONTI	669.80	435.37	234.43
6242	PONTIC PORC SEMPREC.	669.80	435.37	234.43
6240	PORC/GOLD PONTIC	746.75	485.39	261.36
6210	CAST GOLD PONTIC	702.58	456.68	245.90
6220	PONTICS STEELE'S FAC	149.89	97.43	52.46
6230	PONTICS TRU-PONTIC	149.89	97.43	52.46
5281	UNILAT PARTIAL/UNIT	655.75	426.24	229.51
6235	PIN FACING PONTIC	149.89	97.43	52.46
2910	RECEMENT INLAY	65.57	42.62	22.95
2920	RECEMENT CROWN	65.57	42.62	22.95
6930	RECEMENT BRIDGE	84.31	54.80	29.51
PROSTHODONTICS		**Fee Schedule**	**Insur - 65%**	**Pt Copay - 35%**
5110	DENTURE UPPER	1,313.25	853.61	459.64
5120	DENTURE LOWER	1,313.25	853.61	459.64
5211	UPPER PARTIAL-RESIN	861.84	560.20	301.64
5212	LOWER PARTIAL-RESIN	861.84	560.20	301.64
5213	UPPER PARTIAL-METAL	1,313.25	853.61	459.64
5214	LOWER PARTIAL-METAL	1,313.25	853.61	459.64
6940	SIMPLE STRESS BREAK	193.05	125.48	67.57
5820	STAYPLATE UPPER DEN	390.69	253.95	136.74
5821	STAYPLATE -LOWER DEN	390.69	253.95	136.74
5410	ADJ COMPLT UPPER DEN	52.53	34.14	18.39
5411	ADJ COMPLT LOWER DEN	52.53	34.14	18.39
5850	TISSUE COND.-UPPER	82.73	53.77	28.96
5700	DENTURE DUPL. JUMP	275.78	179.26	96.52
5422	ADJ PARTIAL LOWER DN	52.53	34.14	18.39
5510	REPAIR COMPLT DENTUR	101.12	65.73	35.39
5520	REPLACE TEETH-COMPLT	101.12	65.73	35.39
5730	RELINE-UPPER DENTURE	206.84	134.45	72.39
5731	RELINE-LOWER DENTURE	206.84	134.45	72.39
5740	RELINE-UPPER PARTIAL	206.84	134.45	72.39
1510	FIXED SPACE MAINTAIN	206.84	134.45	72.39
1525	REMOV SPACE MAINT.	399.88	259.92	139.96
1520	SPACE MAINT-UNILATRL	372.31	242.00	130.31
1511	FIXED S.S. CROWN TYP	183.86	119.51	64.35
1515	LING. ARCH SPACE MNT	367.71	239.01	128.70
5741	RELINE-LOWER PARTIAL	206.84	134.45	72.39
5750	RELINE-UPPER(LAB)	275.78	179.26	96.52
5751	RELINE LOWER(LAB)	275.78	179.26	96.52
5760	RELN-UPPER PART(LAB)	275.78	179.26	96.52
5761	RELN-LOWER PART(LAB)	275.78	179.26	96.52
5610	REPAIR RESIN/BASE	119.51	77.68	41.83
5620	REPAIR CAST FRAMEWRK	133.29	86.64	46.65
5630	REPAIR BROKEN CLASP	160.87	104.57	56.30
5640	REPLACE BRKN TOOTH	101.12	65.73	35.39
5650	ADD TOOTH TO PARTIAL	137.89	89.63	48.26
5660	ADD CLASP TO PARTIAL	165.47	107.56	57.91
5710	REBASE UPPER DENTURE	367.71	239.01	128.70
5711	REBASE LOWER DENTURE	367.71	239.01	128.70

5720		REBASE UPPER PARTIAL	367.71	239.01	128.70
5721		REBASE LOWER PARTIAL	367.71	239.01	128.70
5750		RELINE REDO - NO RVU	275.78	179.26	96.52
5851		TISSUE COND.-LOWER	82.73	53.77	28.96
5620		REPAIR DENTURE-TOOTH	110.32	71.71	38.61
5690		EA ADDED TOOTH/CLASP	101.12	65.73	35.39
5691		PART DENTURE REPAIR	119.51	77.68	41.83
5670		REATTACH CLASP	101.12	65.73	35.39

EXHIBIT "1"

ADA = American Dental Association

Note: Any procedure or code not listed above is considered a Non-Covered Benefit and applicable current UCR Fee will be charged

POSTERIOR COMPOSITES LOCAL ADVANTAGE 2010

EXHIBIT "1"

QSI	ADA		DESCRIPTION	2010	Insurance	Patient Copay
*** POSTERIOR COMPOSITE FOR RESTORATIVE PURPOSES *** (patient requests posterior composite instead of silver alloy/amalgam - caries present)					Insur - Note	Pt Copay -Note
226	2391		POSTERIOR COMP 1SURF	144.46	85.22	59.24
227	2392		POSTERIOR COMP 2 SURF	202.24	101.45	100.79
228	2393		POSTERIOR COMP 3SURF	240.76	125.80	114.96
229	2394		POSTERIOR COMP 4SURF	264.84	145.00	119.84
77 (to replace an existing alloy)					Insur- 50%	Pt Copay -50%
234	2391		POSTERIOR COMP 1SURF	144.46	72.23	72.23
235	2392		POSTERIOR COMP 2 SURF	202.24	101.12	101.12
236	2393		POSTERIOR COMP 3SURF	240.76	120.38	120.38
229	2394		POSTERIOR COMP 4SURF	264.84	132.42	132.42

Note: Insurance Pays Amalgam Allowance - Patient Copay is Local Advantage Fee less Amalgam Insurance Portion

EXHIBIT "1"

SPECIALTY RATES

FOLLOWING FEES APPLY ONLY WHEN WORK PERFORMED BY LOCAL ADVANTAGE IN - NETWORK SPECIALIST

Insurance payment to an out of network specialist will only be granted if pre-authorization is obtained

PERIODONTICS			2010			
QSI	ADA	DESCRIPTION	2006 UCR	85% UCR	INSURANCE 50%	PT COPAY 50%
	9310	**CONSULTATION SPECIALIST**	**140.00**	**119.00**	**59.50**	**59.50**
	4341	SPEC ROOT PLANNING SCALES	284.00	241.00	120.70	120.70
	4210	GINGIVECTOMY/QUAD	1072.00	911.20	455.60	455.60
	4263	OSSEOUS GRAFT	258.00	219.30	109.65	109.65
	4271	FREE GINGIVAL GRAFT	740.00	629.00	314.50	314.50
	4260	OSSEOUS SURGERY-QUAD	1750.00	1487.50	743.75	743.75
	4261	OSSEOUS SURGERY 1-3 TEETH	1100.00	935.00	467.50	467.50
	4249	CROWN LNGTHN/HRD-SOFT	707.00	600.95	300.48	300.48
	4268	GUIDED TISSUE REGENERATION	650.00	552.50	276.25	276.25
	3450	ROOT AMPUTAT/ROOT	375.00	318.75	159.38	159.38
	9940	NIGHT GUARD	400.00	340.00	170.00	170.00

ENDODONTICS			2010			
QSI	ADA	DESCRIPTION	2006 UCR	85% UCR	INSURANCE 50%	PT COPAY 50%
	9310	**CONSULTATION SPECIALIST**	**120.00**	**102.00**	**51.00**	**51.00**
	3310	ROOT CANAL ANTERIOR	785.00	667.25	333.63	333.62
	3320	ROOT CANAL BICUSPID	885.00	752.25	376.13	376.12
	3330	ROOT CANAL MOLAR	1050.00	892.50	446.25	446.25
	3346	RETREAT RC-ANTERIOR	785.00	667.25	333.63	333.62
	3347	RETREAT RC-BICUSPID	885.00	752.25	376.13	376.12
	3348	RETREAT RC- MOLAR	1050.00	892.50	446.25	446.25
	3410	APICO-ANTERIOR	785.00	667.25	333.63	333.62
	3420	APICO+RC RETROGRADE	785.00	667.25	333.63	333.62
	3421	APICO-BICUS1ST ROOT	885.00	752.25	376.13	376.12
	3425	APICO-MOLAR-1ST ROOT	996.00	846.60	423.30	423.30
	3426	APICO EA ADD ROOT	225.00	191.25	95.63	95.62
	3430	RETRO FILLING/ROOT	215.00	182.75	91.38	91.37

ORAL SURGERY			2010			
QSI	ADA	DESCRIPTION	2006 UCR	85% UCR	INSURANCE 50%	PT COPAY 50%
	9310	**CONSULTATION SPECIALIST**	**120.00**	**102.00**	**51.00**	**51.00**
	7110	EXTRACTION SIMPLE	125.00	106.25	53.13	53.13
	7120	EXTRACTION ADDNT	115.00	97.75	48.88	48.88
	7140	EXT SIMPLE, ADD OR ROOT	140.00	119.00	59.50	59.50
	7210	SURG EXT ERUPT	275.00	233.75	116.88	116.87
	7220	EXTRACT SOFT TISSUE	305.00	259.25	129.63	129.62
	7230	EXTRACT PART BONY	380.00	323.00	161.50	161.50

7240	EXTRACT FULL BONY	450.00	382.50	191.25	191.25
7250	REMOVE RESIDUAL ROOT	255.00	216.75	108.38	108.38
7260	CLOS.,ORAL-MAX SINUS	100.00	85.00	42.50	42.50
7272	TRANSPLANT TOOTH/BUD	550.00	467.50	233.75	233.75
7280	CROWN EXPOSURE	425.00	361.25	180.63	180.63
7281	CROWN EXPOSURE	350.00	297.50	148.75	148.75
7285	BIOPSY-HARD TISSUE	680.00	578.00	289.00	289.00
7286	BIOPSY OF TISSUE	350.00	297.50	148.75	148.75
7286	BIOPSY TISS-INCISION	300.00	255.00	127.50	127.50
7310	ALVEOLECTOMY/QUAD/EX	225.00	191.25	95.63	95.63
7320	ALVEOLECTOMY/QUAD/ED	850.00	722.50	361.25	361.25
7340	VESTIBULOPLASTY	225.00	191.25	95.63	95.63
7341	ALVEOPLASTY/RIDGE XT	225.00	191.25	95.63	95.63
7360	REDUCE TUBEROSITY UN	225.00	191.25	95.63	95.63
7430	EXCS BEN. TUMOR-SMLL	535.00	454.75	227.38	227.38
7431	EXCS BEN. TUMOR-LRG	900.00	765.00	382.50	382.50
7440	RESECTION MAL TUMOR	269.00	228.65	114.33	114.33
7450	EXCISION OF CYST,SML	650.00	552.50	276.25	276.25
7451	EXCISION OF CYST,LRG	950.00	807.50	403.75	403.75
7470	REMOVE TORUS-MAX/MAND	775.00	658.75	329.38	329.38
7510	INTRA-ORAL INCISION	190.00	161.50	80.75	80.75
7520	EXTRA-ORAL INCISION	190.00	161.50	80.75	80.75
7530	FOREIGN BODY REMOVAL	335.00	284.75	142.38	142.38
7550	SEQUESTRECTOMY	230.00	195.50	97.75	97.75
7560	MAXILLARY SINUSOTOMY	800.00	680.00	340.00	340.00
7670	ALVEOLUS-STABL TEETH	153.00	130.05	65.03	65.03
7960	FRENECTOMY	475.00	403.75	201.88	201.87
7971	EXCISION PERICORONAL	150.00	127.50	63.75	63.75
9220	ANESTHESIA GENERAL	375.00	318.75	159.38	159.38
9221	ANES. GEN. each + 15 minutes	100.00	85.00	42.50	42.50

PATIENT COPAY IS THE DIFFERENCE BETWEEN SPECIALIST UCR AND INSURANCE COPAYMENT